ATTACHMENT 12
ADA 2000 Claim Form instructions

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so in the Wisconsin Medicaid Dental Services Handbook.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Element 1 — Dentist's Pre-Treatment Estimate, Dentist's Statement of Actual Services, Specialty (not required)

Element 2 — Medicaid Claim, EPSDT, Prior Authorization # (required, if applicable)

EPSDT (HealthCheck): HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). If the services were performed as a result of a HealthCheck/EPSDT exam, check the EPSDT box.

Prior authorization #: Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Dental Request Form (PA/DRF), if applicable. Do not attach a copy of the PA/DRF to the claim. Services authorized under multiple PA requests must be submitted on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Elements 3-7 — Carrier Name, Carrier Address, City, State, ZIP Code (not required)

Element 8 — Patient Name (Last, First, Middle)

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Elements 9-11 — Patient's Address, City, State (not required)

Element 12 — Date of Birth (MM/DD/YYYY)

Enter the recipient's birth date in MM/DD/YYYY format (e.g., March 27, 1972, would be 03/27/1972).

Element 13 — Patient ID

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Elements 14-16 — Patient's Sex, Phone Number, Zip Code (not required)

Element 17 — Relationship to Subscriber/Employer (not required)

Element 18 — Employer/School (not required)

Element 19 — Subs/Emp. ID#/SSN# (not required)

Element 20 — Employer Name (not required)

Element 21 — Group# (not required)

Element 22-30 — Subscriber/Employer Name (Last, First, Middle), Address, Phone Number, City, State, ZIP Code, Date of Birth (MM/DD/YYYY), Marital Status, Sex (not required)

Element 31 — Is Patient Covered by Another Plan (not required)

Element 32 — Policy # (not required)

Element 33 — Other Subscriber's Name (required, if applicable)

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. This means the provider is required to make a reasonable effort to exhaust all existing commercial health insurance sources before billing Wisconsin Medicaid unless the service is not covered by insurance. Wisconsin Medicaid uses Element 33 to identify commercial health insurance information.

Recipients with commercial health or dental insurance coverage
Commercial health or dental insurance coverage must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid. Commercial health insurance coverage is indicated by the EVS under "Other Commercial Health Insurance."

When commercial dental or health insurance paid for some services
When commercial dental or health insurance paid only for some services and denied payment for the others, Wisconsin Medicaid recommends providers submit two separate Medicaid claim forms. To maximize Medicaid reimbursement, one claim should be submitted for the partially paid services and another for the services denied by commercial dental or health insurance.

When the EVS indicates the code "DEN" for "Other Coverage," commercial dental insurance must be billed prior to billing Wisconsin Medicaid for dental sealants and one of the following insurance codes must be indicated in this element:

Code	When to use code
OI–P (other insurance paid)	PAID in part or in full by commercial health insurance or commercial HMO. In Element 59, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI–D (other insurance denied)	Use OI-D for dental claims in either of the following situations: • DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, *or* payment was applied towards the coinsurance and deductible. • YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.
None. Providers may leave this element blank.	N/a.
Note: The provider may not use OI-D if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.	

The following table lists appropriate provider responses to special circumstances when billing commercial health or dental insurance prior to billing Wisconsin Medicaid:

Situation	Appropriate response
No insurance indicator is indicated by Medicaid's EVS.	• Leave Element 33 blank.
Provider: • Is aware of other commercial health or dental insurance not indicated on the EVS. • Bills the insurance. • Receives reimbursement from the insurer.	• Place "OI–P" in Element 33. • Place the amount paid by commercial health or dental insurance in the "Payment by other plan" box in Element 59. • Complete the Other Coverage Discrepancy Report (HCF 1159) Rev. 10/02, located on the forms section of the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* . Providers without Internet access may request a copy by calling Provider Services at (800) 947-9627 or (608) 221-9883.
Provider: • Is aware of other commercial health or dental insurance not indicated on the EVS. • Bills the insurance. • Does not receive reimbursement from that insurer.	• Leave Element 33 and the "Payment by other plan" box in Element 59 blank. • Complete the Other Coverage Discrepancy Report to update Medicaid files.

Element 34 — Date of Birth (MM/DD/YYYY) (not required)

Element 35 — Sex (not required)

Element 36 — Plan/Program Name (not required)

Element 37 — Employer/School (not required)

Element 38 — Subscriber/Employer Status (not required)

Element 39 — Subscriber/Employee Signature (not required)

Element 40 — Employer/School (not required)

Element 41 — Employee/Subscriber Signature Authorizing Payment (not required)

Element 42 — Name of Billing Dentist or Dental Entity

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and Zip code. If the billing provider is a group or clinic, enter the group or clinic name in this element. The name in Element 42 must match the provider identification number in Element 44.

Element 43 — Phone Number (not required)

Element 44 — Provider ID

Enter the billing provider's eight-digit Medicaid provider number. The provider number in this element must match the provider name indicated in Element 42.

Element 45 — Dentist Soc. Sec. or T.I.N. (not required)

Element 46 — Address

Enter the billing provider's complete street address. If providers move or are at a different address, they should complete the Wisconsin Medicaid Provider Change of Address or Status form (HCF 1181) Rev. 09/02, to notify Wisconsin Medicaid that an address change has occurred. The form is located on the forms section of the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* . Providers without Internet access may request a copy by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Element 47 — Dentist License # (not required)

Element 48 — First Visit Date of Current Series (not required)

Element 49 — Place of Treatment

Enter the appropriate two digit place of treatment (place of service) code for each service. Check the "Office" box with an "X" and enter:

POS Code	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
50	Federally Qualified Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Elements 50-52 — City, State, ZIP code

Enter the billing provider's complete city, state, and Zip code as they appear on the Medicaid certification letter.

Element 53 — Radiographs or Models Enclosed? (not required)

Element 54 — Is treatment for Orthodontics? (not required)

Element 55 — If Prosthesis (Crown, Bridge Dentures), Is This Initial Placement? (not required)

Element 56 — Is Treatment Result of Occupational Illness or Injury? (not required)

Element 57 — Is Treatment Result of: Auto Accident? Other Accident? Neither? (not required)

Element 58 — Diagnosis Code Index (not required)

Element 59 — Examination and Treatment Plans

Date (MM/DD/YYYY): Enter the date of service in MM/DD/YYYY format (e.g., November 1, 2003, would be 11/01/2003) for each detail.

Tooth: If the procedure applies to only one tooth, the tooth number or tooth letter is entered here. Enter one tooth per line.

Surface: Enter the tooth surface(s) restored for each restoration.

Diagnosis Index #: Not required by Wisconsin Medicaid.

Procedure Code: Enter procedure code D1351 — sealant - per tooth.

Qty: Enter the exact quantity billed. When multiple quantities of a single type of service are provided on the same day, list the code only once with the appropriate quantity indicated at the end of the description. (This does not apply to codes that require modifiers.) Enter only one tooth per line.

Description: Write a brief description of each procedure.

Fee: Enter the usual and customary charge for each detail line of service.

Total Fee: Enter the total of all detail charges.

Payment by Other Plan: Enter the actual amount paid by dental insurance. (If the dollar amount indicated in Element 59 is greater than zero, "OI-P" must be indicated in Element 33.) Do not include the Wisconsin Medicaid copayment amount. If the dental insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Max. Allowable: Not required by Wisconsin Medicaid.

Deductible: Not required by Wisconsin Medicaid.

Carrier Pays: Not required by Wisconsin Medicaid.

Patient Pays: Not required by Wisconsin Medicaid. Do not enter recipient copayment amounts.

Admin. Use Only: Not required by Wisconsin Medicaid.

Element 60 — Identify All Missing Teeth With "X" (not required)

Element 61 — Remarks for Unusual Services (required, if applicable)

List any unusual services, including reasons why limitations were exceeded.

Element 62 — Dentist's Signature Block

The provider or the authorized representative must sign in Element 62. The month, day, and year the form is signed must also be entered in MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with a date.

If Elements 42 and 44 indicate a clinic or group biller, indicate the Medicaid-certified performing provider's name and eight-digit Medicaid provider number in this element.

Elements 63-65 — Address Where Treatment Was Performed, City, ZIP Code (not required)